



reinhealth

IV Antibiotic, Antiviral and Antifungal Referral Form

Please fax completed order form to 972-499-9210

*** Please include demographics, most recent H&P, lab and culture results, clinical notes, discharge summary, operative report and MAR**

Patient's name: _____ Date of birth: _____ Phone #: _____

Diagnosis _____ ICD 10 code (required) _____

Weight _____ Height _____ Allergies _____

Patient's Primary Care Physician: _____ NPI #: _____

PCP Phone #: _____ PCP Fax #: _____

- IV antibiotics (Pharmacy Only), **NO** Infectious Disease Consult
- IV antibiotics **WITH** Infectious Disease Consult
- Place PICC line for medication administration
- Does patient have pacemaker? No Yes—If yes, may verify PICC line placement with CXR
- Patient will need a first dose and teaching
 - Flush IV access device with heparin/saline per INS protocol
 - Weekly & PRN dressing changes for IV access
 - Administer Cathflo 2mg IV PRN for occluded catheter
 - *** (Only use as needed for thrombotic occlusion, if needed) May Refill PRN

Patient Preferred Location:

- Lewisville**
2790 Lake Vista Dr.
Lewisville, TX 75067
- Dallas**
11970 N. Central Expy. #630
Dallas, TX 75243
- Plano**
5425 Spring Creek Pkwy. #135
Plano, TX 75024
- Rowlett**
6800 Heritage Pkwy. #105
Rowlett, TX 75087
- Denton**
2800 Shoreline Dr. #270
Denton, TX 76210

Initiation/Continuation of infusion therapy orders

DRUG	DOSE	ROUTE	FREQUENCY	DURATION

Lab orders and Frequency:

Pharmacist may adjust medication dosage, per ReinHealth protocol, based on lab results

Additional Comments/Orders: _____

Prescriber's Printed Name: _____

Prescriber's Signature: _____ Date: _____